



MEDICAID UNDUE HARDSHIP WAIVER REQUEST

Case Name Case Number

Use this form to request an undue hardship waiver or to authorize the medical facility where you reside to file on your behalf. Please describe in the space provided on the back of this form the extent of your hardship and how this divestment penalty will endanger your health, life, or deprive you of food, clothing, shelter, or other necessities of life.

In addition to your statement on the back of this form, you will need to submit the following verification:

- 1. A statement signed by you (or your authorized representative) which describes whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets.

AND

- 2. Proof that an undue hardship would exist if the penalty period is applied (as follows).

If you are currently institutionalized, you must submit:

- A copy of the notification sent from the Long Term Care facility which states both the date of involuntary discharge and alternative placement location or other proof that if the hardship waiver is not granted, you will be deprived of medical care such that your health or life would be endangered or deprived of food, clothing, shelter, or other necessities of life.

If you are applying for Community Waivers, Family Care, PACE or Partnership, submit:

- An estimate of the cost of the Long Term Care services needed to meet your medical and remedial needs, as determined by your Care Manager; and
• An estimate of your monthly costs for food, shelter, clothing and other necessities of life.

Send this completed form along with the requested verification to your local agency indicated on the attached Undue Hardship Notice. Failure to send this completed request form will result in you remaining ineligible for Wisconsin Medicaid Long Term Care services for the divestment penalty period indicated in the notice.

Authorization for the medical facility to represent you

The medical facility where you reside can also make the undue hardship request for you but they must have your permission to do so. If you would like the medical facility where you reside to help you request an undue hardship, please check the following box and list the facility's name.

I _____ authorize _____
Print Your Name Name of Facility

to file an undue hardship waiver request on my behalf, for the purpose of determining whether or not an undue hardship exists.

The medical facility where you reside can also represent you during the appeal process if your undue hardship request is denied, if the medical facility has your permission to do so. Please check the box next to the following statement and identify the medical facility where you reside to authorize that facility to represent you throughout the appeal process if you decide to appeal the denial of your undue hardship request.

I _____ authorize _____
Print Your Name Name of Facility

to represent me and/or file an appeal on my behalf regarding the denial of my undue hardship request.

Use the space below for your hardship waiver request. Attach a separate piece of paper if you need more room.

I declare that, under penalty of perjury or false swearing, that all of the information I have provided is correct and complete to the best of my knowledge.

SIGNATURE – Applicant

Date Signed